## Alabama Medicaid Pharmacy Miscellaneous PA Request Form

FAX: (800) 748-0116 Phone: (800) 748-0130	Fax or Mail to Kepro		Aubui	P.O. Box 3210 Auburn, AL 36831-3210	
		PATIENT INFORMATION		-	
Patient name		Patient	Medicaid #		
Patient DOB	Patient pho	one # with area code	Nursing home r	esident   Yes	
		PRESCRIBER INFORMATION			
Prescriber name		NPI #	License #		
Phone # with area code		Fax # with a	rea code		
Address (Optional)					
Street or PO Box /C	•				
		y and meets the guidelines for use a mentation is available in the patient		caid Agency. I will be	
		Prescribing pra	ctitioner signature	Date	
	DIS	PENSING PHARMACY INFORMA	TION —	_	
Dispensing pharmacy		NPI #	<del>‡</del>		
		Fax # with area code			
		ug Requested			
		DRUG/CLINICAL INFORMATION Required for all requests	N		
☐ EPSDT/Medical Necessity R	equest	Quantity per month	Days suppl	у	
☐ Compounding Max Cost Ove	-			fills: 0 1 2 3 4 5 Other	
Drug Requested	-				
		ICD-10 Code			
Diagnosis		ICD-10 Code			
☐ Initial Request	☐ Renewal				
Medical justification					
☐ Additional medical justificatio	n attached	☐ EPSDT Referral Form atta	ached		
For compounding max cost overr	ide requests, plea	ase include the following:			
Compounding Ingredients:					
Ingredient Name			<u> </u>		
Ingredient Name			<u> </u>		
Ingredient Name			<u> </u>		
Ingredient Name  If more ingredients are required, attach add	ditional sheets.	Quantity Required	NDC		
		FOR KEPRO USE ONLY			
☐ Approve request ☐ Deny	request □ I	Modify request ☐ Medicaid e	ligibility verified		
	•	,	- ,		
Reviewer's Signature		Response Date/Hour			

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